

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list the 5 major health concern in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II **Please check mark the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.**

Category I	0	1	2	3
Feeling that bowels do not empty completely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdominal pain relief by passing stool or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternating constipation and diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard dry or small stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coated tongue of "fuzzy" debris on tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pass large amount of foul smelling gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 3 bowel movements daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use laxatives frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category II	0	1	2	3
Excessive belching burping or bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas immediately following a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offensive breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sense of fullness during and after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty digesting fruits and vegetables; undigested foods found in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category III	0	1	2	3
Stomach pain, burning or aching 1- 4 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently use antacids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling hungry an hour or two after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn when lying down or bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporary relief from antacids, food, milk, carbonated beverages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems subside with rest and relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category IV	0	1	2	3
Roughage and fiber cause constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion and fullness lasts 2-4 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain, tenderness, soreness on left side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under rib cage bloated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive passage of gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool undigested, foul smelling, Mucous-like, greasy or poorly formed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased thirst and appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category V	0	1	2	3
Greasy or high fat foods cause distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower bowel gas and or bloating several hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bitter metallic taste in mouth, especially in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained itchy skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yellowish cast to eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool color alternates for clay colored to normal brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reddened skin, especially palms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry or flaky skin and/or hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of gallbladder attacks or stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your gallbladder removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category VI	0	1	2	3
Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depend on coffee to keep yourself going or started	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get lightheaded and if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating relieves fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel shaky, jittery, tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitated, easily upset, nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor memory, forgetful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category VII	0	1	2	3
Fatigue after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating sweets does not relieve cravings for sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Must have sweets after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waist girth is equal or larger than hip girth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased thirst & appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Category VIII	0	1	2	3
Cannot stay asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crave salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow starter in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness when standing up quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches with exertion or stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weak nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category IX

- Cannot fall asleep
- Perspire easily
- Under high amounts of stress
- Weight gain when under stress
- Wake up tired even after 6 or more hours of sleep
- Excessive perspiration or perspiration with little or no activity

Category X

- Tired, sluggish
- Feel cold – hands, feet, all over
- Require excessive amounts of sleep to function properly
- Increase in weight gain even with low-calorie diet
- Gain weight easily
- Difficult, infrequent bowel movements
- Depression, lack of motivation
- Morning headaches that wear off as the day progresses
- Outer third of eyebrow thins
- Thinning of hair on scalp, face or genitals or excessive falling hair
- Dryness of skin and/or scalp
- Mental sluggishness

Category XI

- Heart palpitations
- Inward trembling
- Increased pulse even at rest
- Nervousness and emotional
- Insomnia
- Night sweats
- Difficulty gaining weight

Category XII

- Diminished sex drive
- Menstrual disorders of lack of menstruation
- Increased ability to eat sugars without symptoms

Category XIII

- Increased sex drive
- Tolerance to sugars reduced
- “Splitting” type headaches

Category XIV (Male Only)

- Urination difficulty or dribbling
- Urination frequent
- Pain inside of legs or heels
- Feeling of incomplete bowel evacuation
- Leg nervousness at night

Category XV (Males Only)

- Decrease in libido
- Decrease in spontaneous morning erections
- Decrease in fullness of erections
- Difficulty in maintain morning erections
- Spells of mental fatigue
- Inability to concentrate
- Episodes of depression
- Muscle soreness
- Decrease in physical stamina
- Unexplained weight gain
- Increase in fat distribution around chest and hips
- Sweating attacks
- More emotional then in the past

Category XVI (Menstruating Females Only)

- Are you a menopausal **Yes** **No**
- Alternating menstrual cycle lengths **Yes** **No**
- Extended menstrual cycle, greater than 32 days **Yes** **No**
- Shortened menses, less than every 24 days **Yes** **No**
- Pain and cramping during periods
- Scanty blood flow
- Heavy blood flow
- Breast pain and swelling during menses
- Pelvic pain during menses
- Irritable and depressed during menses
- Acne break outs
- Facial hair growth
- Hair loss/thinning

Category XVII (Menopausal Females only)

- How many years have you been menopausal? _____
- Do you ever have uterine bleeding since menopause? **Yes** **No**
- Hot flashes
- Mental foginess
- Disinterest in sex
- Mood swings
- Depression
- Painful intercourse
- Shrinking breast
- Facial hair growth
- Acne
- Increased vaginal, pain, dryness or itching

PART III

- How many alcohol beverages they consume per week? _____
- How many caffeinated beverages do you consume per day? _____
- How many times do you eat out per week? _____
- How many times a week do you eat raw nuts or seeds? _____
- How many times a week do you eat fish? _____
- How many times a week do you workout? _____
- List the three worst foods you eat during the average week? _____, _____, _____
- List the three healthiest foods you eat during the average week? _____, _____, _____
- Do you smoke? _____ If yes, how many times a day _____, a week _____.
- Rate your stress levels on a scale of 1-10 during the average week. _____

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: